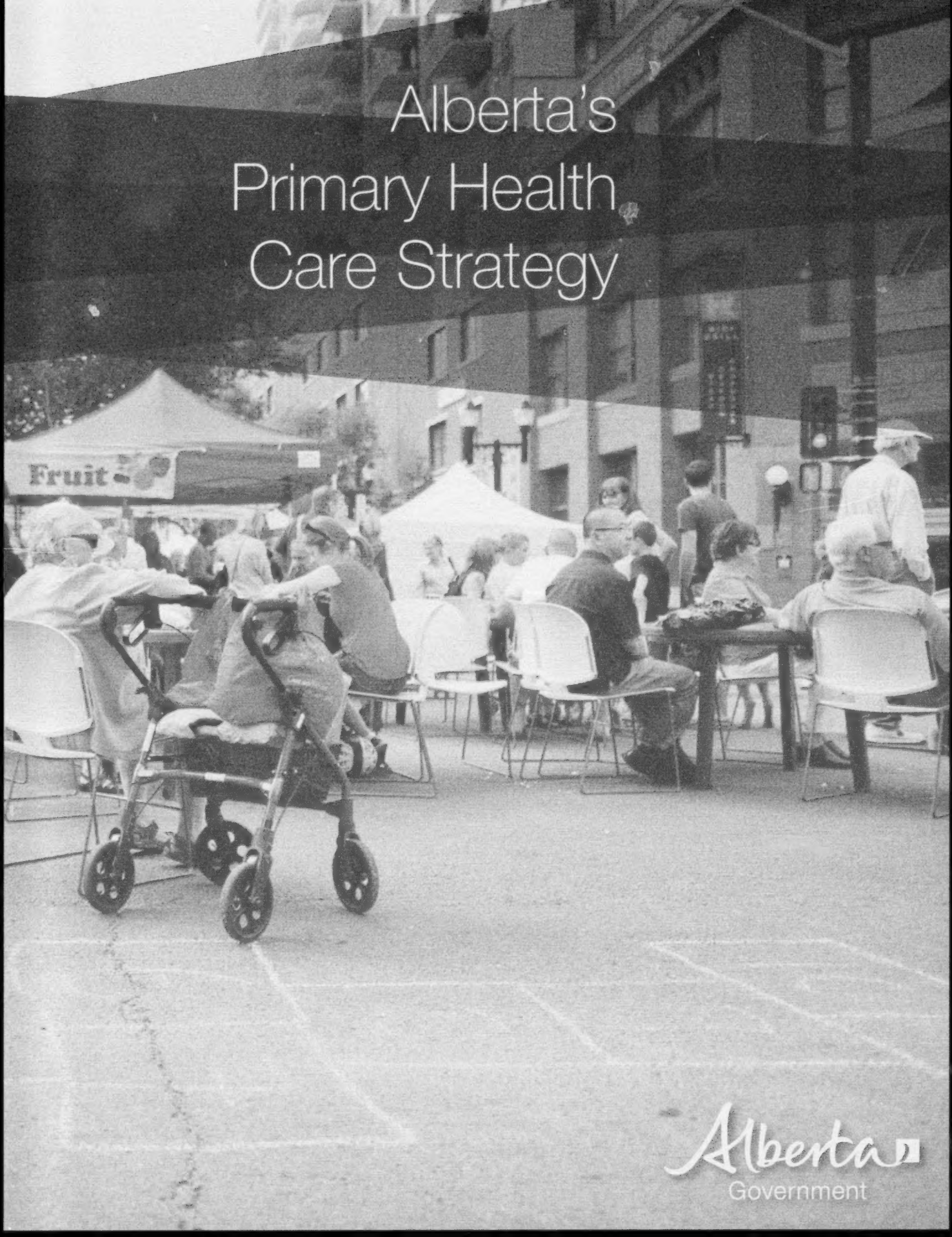
Alberta's Primary Health Care Strategy



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Letter from the Minister of Health

Good quality primary health care is the foundation for a healthier Alberta. It's not as easy to point to as a new hospital or a research centre. Make no mistake, though: improving our primary health care system so that everyone has a home in the health system is critical. Unless we take action now, an Alberta where everyone is as healthy as they can be will remain an unattainable vision.

Why? Because we have over four million people living in the province now and within the next 20 years, another million is expected. The face of care is changing, too, away from treatment in hospitals to helping people manage chronic diseases in their daily lives. To improve how care is delivered and received, we have to organize our services better and harness the capacity of providers and of those in need of care.

Alberta's Primary Health Care Strategy marks the start of a long-term transformation and provides us with the direction to get there. We have commitment from leadership throughout the health system and across the Government of Alberta to move the primary health care system forward.

It will take a lot of hard work to realize the three strategic directions set out in this strategy: enhancing the delivery of care, changing the culture of health care, and creating the building blocks for change. Yet I am confident we can do it. We have some shining examples of success to build upon and are already building momentum through initiatives underway such as Family Care Clinics and Primary Care Networks. So let's keep going.

This strategy would never have been developed without the people who provided their expertise. I would like to thank four groups in particular:

- The Primary Health Care Strategy Working Group — your expertise and tireless enthusiasm for improving Alberta's primary health care system are greatly appreciated. You have been instrumental in shaping this strategy and I am grateful for your advice and guidance.
- The seven Expert Advisory Groups — your in-depth knowledge, insights, and advice contributed greatly to the development of this strategy.
- The Minister's Advisory Committee on Primary Health Care — you offered sage advice throughout the development of the Family Care Clinics and this strategy.
- The department of Health — you have been instrumental in doing the policy work and bringing together the necessary research and supports to identify issues and plan for the future.

Better care. Better outcomes. Better value. We can and have to deliver on all three of these by transforming primary health care, in order to address the challenges of a growing, aging, and increasingly diverse province. Together, we can make Alberta a leader in primary health care.

Honourable Fred Horne
Minister of Health

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Acknowledgement of Participants

Alberta's Primary Health Care Strategy has been developed by the Primary Health Care Strategy Working Group, supported by Alberta Health. The Primary Health Care Strategy Working Group includes members with expertise in primary health care delivery, administration, research, education, and community development. Members were selected for their in-depth knowledge of primary health care and demonstrated leadership in transforming Alberta's primary health care system.

Thank you to its members:

- Dr. Rob Wedel (Co-Chair)
- Muriel Davidson (Co-Chair)
- Pierre Bérubé
- Yvonne Chiu
- Greg Eberhart
- Dr. Lee Green
- Dr. Richard Lewanczuk
- Larry McLennan
- Mary-Anne Robinson
- Marianne Stewart
- Dr. Phillip van der Merwe
- Susan Williams

Expert advisory groups were established for seven topics: innovation, cultural change, standards, health system integration, health home and attachment, social and community integration, and performance measures and evaluation. Their discussions and recommendations were an invaluable addition to the preparation of the strategy.

Alberta's Primary Health Care Strategy has also been informed by the Minister's Advisory Committee on Primary Health Care. The committee includes representatives from: Alberta Health Services; Alberta Medical Association; Alberta College of Pharmacists; College and Association of Registered Nurses of Alberta; College of Physicians and Surgeons of Alberta; Nurse Practitioner Association of Alberta; College of Alberta Psychologists; Alberta College of Social Workers; Physiotherapy Alberta College and Association; Alberta College of Family Physicians; College of Licensed Practical Nurses of Alberta; Canadian Association of Physician Assistants; University of Alberta's Department of Occupational Therapy and Department of Family Medicine; University of Calgary's Department of Family Medicine; and Primary Care Alliance.

A full list of participants is provided in Appendix One.

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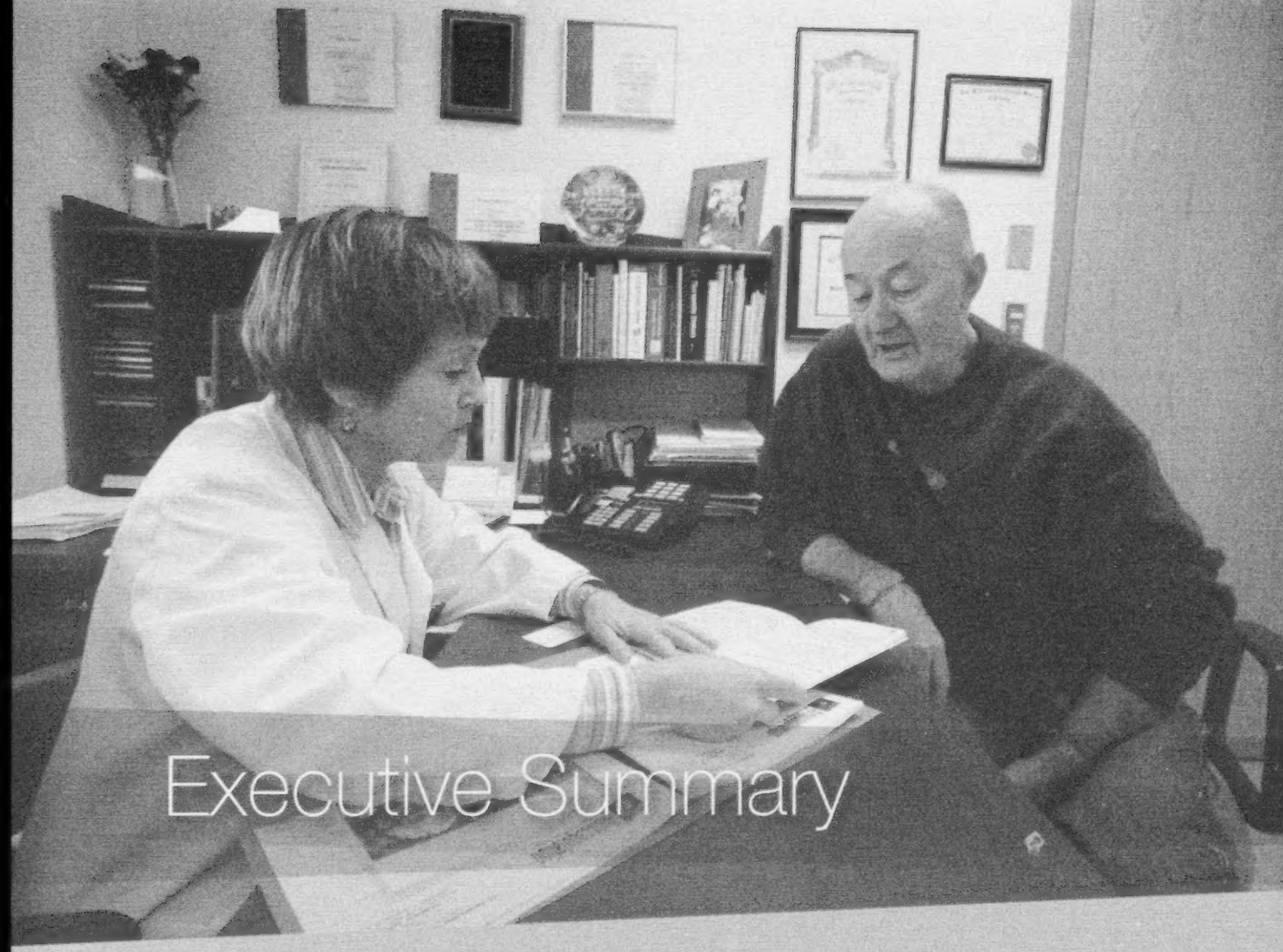

Executive Summary

Alberta has a strong foundation in primary health care delivery. We have a skilled and dedicated health workforce. Most Albertans receive their health care from one of the many Primary Care Networks located throughout the province. These services are augmented by Community Health Centres and Community Mental Health Clinics, and by community health providers such as pharmacists and psychologists. Programs like HealthLink and MyHealth.Alberta.ca are making it easier for Albertans to access health advice and information. Family Care Clinics, the newest entry, have shown promising results and will soon be expanding into more communities.

In a highly complex and quickly evolving field like health care, there is always room for improvement. Research shows that some approaches are more effective than others. Clinics innovate in how they deliver care, and these successes need to be shared with others. In our large province, with the population concentrated in the Edmonton to Calgary corridor, there is not always a match between demand for services and availability of the right health care providers. Parts of the health system may not communicate well with each other, which impacts people's care. And whether social factors that affect an individual's health — like income and housing — are addressed may depend on a health care provider's knowledge and capacity to make a referral. We need to address gaps such as these to create an effective primary health care system that delivers comprehensive care for all Albertans.

Demographic changes will continue to challenge our health system. In the next few decades, Alberta will be home to a million more people needing health services. An increasing number of people will need help living with chronic conditions, and more Albertans will be seniors than ever before. Primary health care needs to continue to evolve to deliver the care Albertans need to stay healthy and have the best possible quality of life.

Alberta's Primary Health Care Strategy sets out the vision for the future: ***a primary health care system that supports Albertans to be as healthy as they can be***. It establishes principles and strategic directions for continuing the transformation of primary health care in Alberta. These describe what needs to be done to further enhance the delivery of care, to change the culture within the system, and to put in place the building blocks for long-term sustainability.

This transformational change won't happen overnight. It will take committed and sustained effort throughout the system. New relationships and ways to work together need to be developed. There are still barriers to a truly integrated health system where primary health care, acute care, specialized services, and community and social services co-ordinate to meet people's needs. People need to get care from the right provider at the right time. More people need a home in the health system, where they can access care from a team of providers that know them and can address their needs. These changes will build on the strengths of the system and workforce that we already have, and prepare us to meet the challenges of the future.

To address these challenges, the strategy sets out three strategic directions:

- **Enhancing the delivery of care** by providing a health home for every Albertan, establishing clear expectations for primary health care delivery, and integrating and co-ordinating services;
- **Bringing about cultural change** within the system through initiatives that: encourage and support people to be more active participants in their care; promote team-based care and collaboration; build and support community partnerships; foster a culture of continuous learning, innovation, and trust within the system; and develop a greater understanding of the social determinants of health; and
- **Establishing building blocks for change,** including: effective governance of the primary health care system; creating compensation models that support innovation and team-based care; common information management and information technology; developing and supporting the primary health care workforce; involving the community in planning and delivering primary health care services; communicating about primary health care; and effective evaluation and quality improvement processes.

This document sets out goals under each of the strategic directions. A related action plan will set out the path to implement the strategy.

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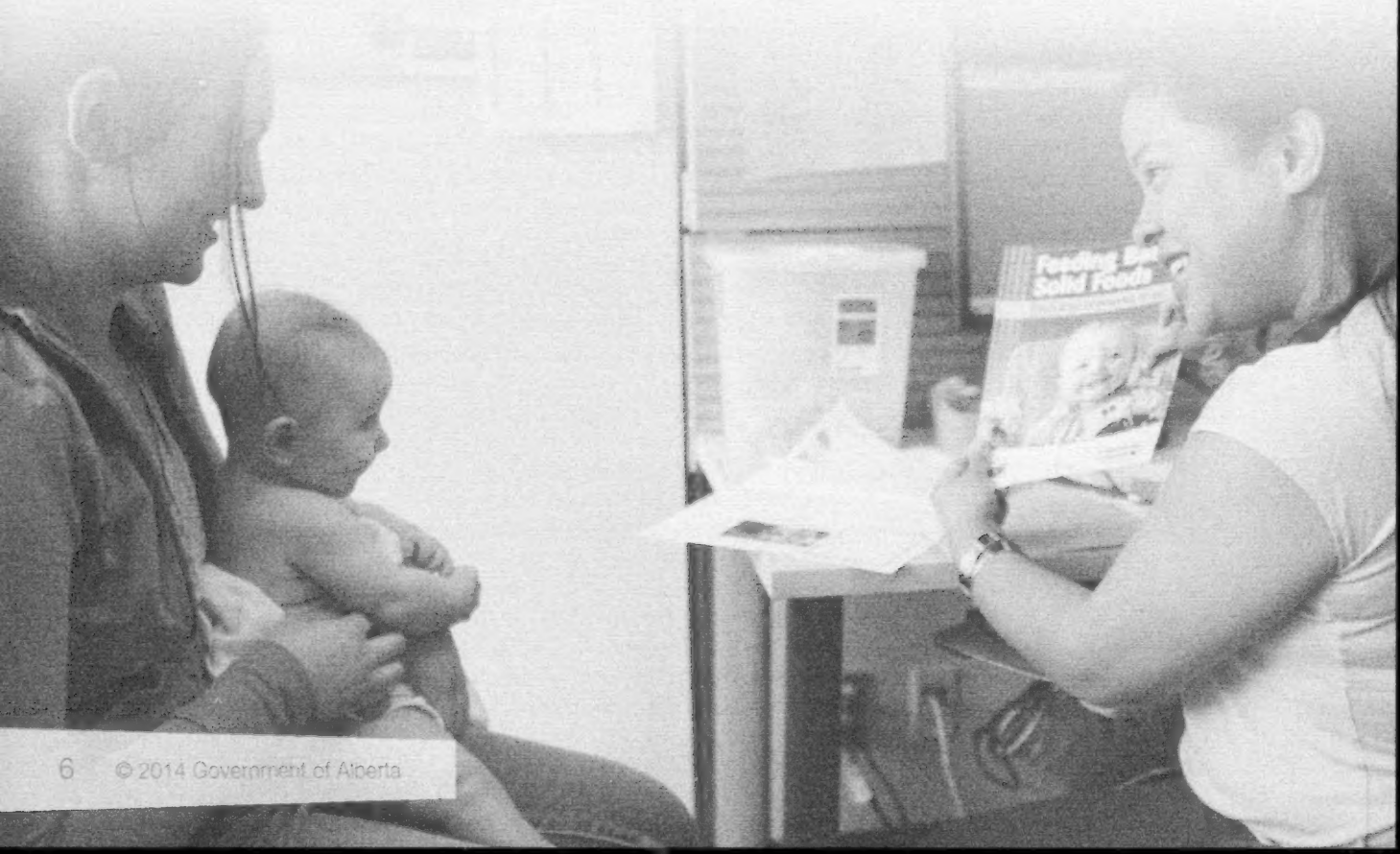
MOVING FORWARD

As the primary health care system evolves, more people will experience a system where:

- Everyone is attached to a primary health care home and experiences care that is well co-ordinated and easily accessible. Providers know the people to whom they provide care and their health needs because they have an ongoing relationship with them;
- The focus is on wellness, prevention, chronic disease management, and systematic screening to detect potential problems early. There is also an emphasis on supporting people in managing their own health;
- Teams of people provide a range of services that move beyond medical care to include mental health and social and community services;
- Access to comprehensive primary health care is available to people across the province;
- Clinics have longer hours of service, people need to make fewer visits to emergency departments, and clinic staff connect people with health, social and community programs;
- Communities participate in planning for services;
- Integrated health records follow the person and help provide continuity of care and reduce duplication; and
- Ways of working together emphasize sharing information and working towards common goals.



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Introduction

Purpose

Alberta's Primary Health Care Strategy sets out a vision for the future: *a primary health care system that supports Albertans to be as healthy as they can be*. It also establishes strategic directions for transforming primary health care in Alberta. These describe what needs to be done to further enhance the delivery of care, change the culture within the system, and put in place the building blocks for long-term change.

Alberta's primary health care transformation is about raising the bar and using all of our resources to improve access, achieve better health outcomes, and ensure everyone has a home in the health system. This means building on what has already been achieved through the establishment of Primary Care Networks and Family Care Clinics, as well as initiatives like Netcare, HealthLink, and work to improve care paths and integration in the health system.

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Defining Primary Health Care

Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions. In Alberta, primary health care includes a wide range of services delivered by teams of providers that can include physicians, nurses, psychologists, pharmacists, dietitians, counsellors, rehabilitation therapists, and social workers, among others, depending on the needs of the people with whom they are working. Social and community initiatives such as housing, employment, and income supports are part of the programming people can draw on to support their overall health and well-being.

The Need for a Healthier Alberta

Despite spending $17 billion a year — the second highest Canadian jurisdiction on a per person basis — Alberta doesn't have the best health outcomes.

- In 2012, only 51 per cent of Albertans rated access to health care services as 'easy'.[1]
- 30 per cent of Albertans have at least one of seven select chronic health conditions, and among seniors, the prevalence increases to more than 75 per cent.[2]
- One in five Canadians will experience a mental illness in their lifetime, and the remaining four will be affected by the mental illness of a friend, family member, or colleague.[3]
- Albertans' life expectancy at birth ranks fourth in the country,[4] despite the province having the second highest per capita spending on health care.
- Use of the health system by about five per cent of Albertans, many of whom have multiple chronic diseases, accounts for 60 per cent of the costs of emergency departments, in-patient care, urgent care, and primary care fee-for-service payments to doctors annually.

Alberta is changing and so are our health issues. Our population is more diverse than ever and comes from all parts of the globe. Although the overall standard of living is high, nearly 10 per cent of Albertans still live below the poverty line. Additionally, the impact of population growth and aging on the health system can't be overestimated: Alberta's population has now reached 4 million and is estimated to be 5 million within the next 20 years. By 2031, one in five Albertans will be a senior.

The things that are making us ill have also changed. Advances in infection and disease control, including reducing the death rate from cancer and heart disease, are helping people live longer. Health care is increasingly about helping people manage chronic diseases such as type two diabetes, cardiovascular disease, addictions, and cancer in the community.

All of these factors have profound implications for our health care and social support systems.

1 Health Quality Council of Alberta (2013). *Satisfaction and Experience with Healthcare Services: A Survey of Albertans 2012*. http://www.hqca.ca/index.php?id=68.

2 Alberta Health Services (2010). *2010-2015 Health Plan: Improving Health for All Albertans*. http://www.albertahealthservices.ca/publications/ahs-pub-2010-2015-health-plan.pdf.

3 Health Canada (2002). *A Report on Mental Illnesses in Canada*. http://www.cpa.ca/cpasite/userfiles/Documents/Practice_Page/reports_mental_illness_e.pdf.

4 Statistics Canada (2012, May 31). *CANSIM Table 102-0512: Life Expectancy at Birth*.

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Primary health care is a critical part of the overall health system. Effective primary health care is co-related with improved population health outcomes, higher user satisfaction, and lower total health care spending. Countries such as New Zealand, Finland, Denmark, and Norway have seen significant improvements in the equity, efficiency, effectiveness, and responsiveness of their health systems following the transformation of their primary health care systems.[5] Primary health care needs to be recognized as the foundation of Alberta's health system and to be integrated with acute and specialist care.

The current structure and funding of Alberta's health system emphasize acute and specialty care. While these are very important, it is primary health care where a wide range of health, community, and social services are delivered and co-ordinated based on people's needs. Primary health care plays a critical role in improving health outcomes, preventing and managing illness, and reducing pressure on other areas of the health system.

Top Chronic Diseases

The top chronic diseases impacting Albertans include:

- Arthritis
- Cancer
- Chronic Obstructive Pulmonary Disorder (COPD)
- Diabetes
- Heart disease
- High blood pressure
- Mood disorders

In spite of the importance of primary health care, too many Albertans still don't have a home in the health system through which they know their providers and can receive timely and co-ordinated care. Primary health care providers also face many structural and attitudinal barriers to providing the best possible care, since the system is not designed to support collaboration, team-based care, or effective co-ordination across the spectrum of health and social services.

> "The transformation of the primary health care system is not a small change and it will not be easy."
>
> *Primary Health Care Strategy Working Group (SWG) Member*

Moving to Primary Health Care

A major part of primary health care transformation is the transition from primary care to primary health care. Primary care, which includes clinical services like diagnosis and treatment of non-urgent conditions, chronic disease prevention and management, and mental health and addiction treatment, is one part of primary health care. Primary health care is a broader concept than primary care, that emphasizes prevention and wellness, and recognizes that success in improving people's health is largely determined by factors in their daily lives, such as: lifestyles, housing, relationships, spiritual beliefs, income, and workplaces.

5 Alberta Health (2013). Health Care Cost Drivers in Alberta. http://www.health.alberta.ca/documents/Health-Care-Cost-Drivers-Alberta-2013.pdf

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Integrating Services to Support Health

Primary Health Care as the Centre of Alberta's Health Care System

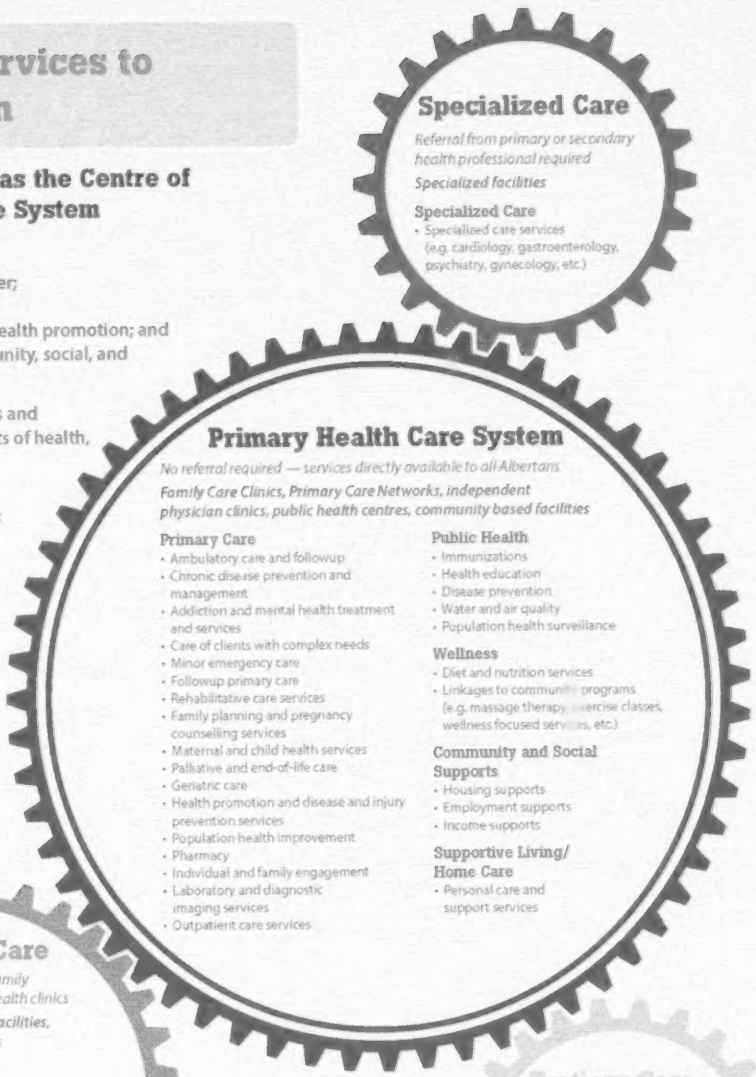
Primary health care is about:

- Direct access to a team member;
- Improved team based care;
- Better health education and health promotion; and
- Integrating health and community, social, and support services.

Primary health care will address and consider the social determinants of health, which include:

- Aboriginal status;
- Early childhood development;
- Educational attainment;
- Employment;
- Food security;
- Housing;
- Income; and
- Social connectedness.

Primary health care is the "front door" to health care.


Specialized Care
Referral from primary or secondary health professional required
Specialized facilities
Specialized Care
• Specialized care services (e.g. cardiology, gastroenterology, psychiatry, gynecology, etc.)
Primary Health Care System
No referral required — services directly available to all Albertans
Family Care Clinics, Primary Care Networks, independent physician clinics, public health centres, community based facilities
Primary Care
• Ambulatory care and followup
• Chronic disease prevention and management
• Addiction and mental health treatment and services
• Care of clients with complex needs
• Minor emergency care
• Followup primary care
• Rehabilitative care services
• Family planning and pregnancy counselling services
• Maternal and child health services
• Palliative and end-of-life care
• Geriatric care
• Health promotion and disease and injury prevention services
• Population health improvement
• Pharmacy
• Individual and family engagement
• Laboratory and diagnostic imaging services
• Outpatient care services
Public Health
• Immunizations
• Health education
• Disease prevention
• Water and air quality
• Population health surveillance
Wellness
• Diet and nutrition services
• Linkages to community programs (e.g. massage therapy, exercise classes, wellness focused services, etc.)
Community and Social Supports
• Housing supports
• Employment supports
• Income supports
Supportive Living/ Home Care
• Personal care and support services
Secondary Care
Not normally provided by family physicians or community health clinics
Hospitals, long term care facilities, community based facilities
Secondary Care
• In-patient services
• Emergency care services
• Medical or surgical treatment services
• Diagnostic laboratory and medical imaging services
• Acute mental and physical health assessment and treatment services
• Same-day treatment services, followup out-patient care services
Tertiary Care
Referral from primary or secondary health professional required
Specialized facilities, hospices
Tertiary Care
• Specialized health care services
• Highly technical health care services
• Advanced diagnostic support services

Primary health care gives Albertans a home in the health system.

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> If we can increase the educational attainment of Albertans, we will increase health, full stop. How do we do that?
>
> *SWG*

Primary health care puts individuals and families at the centre of their care, rather than diseases, providers, or facilities. It involves people in the decisions about their own care and takes into account their physical, mental and social needs. To address these factors, primary health care brings in a wide range of services that have not traditionally been considered 'health services'. In addition to connections with services like public health, continuing care, and home care, primary health care incorporates social programs such as income and housing supports.[6]

Transforming to a Primary Health Care System

Good primary health care is an important part of helping people become and stay healthy. Alberta needs a system where people have a home in the health system and can access a member of their primary health care team the same day, when required. Primary health care needs to better integrate health providers across our communities and better integrate them with the acute care and specialist services that people require, so that all parts of the health system work together smoothly and people are supported in their care journeys. In addition to improving health outcomes, this transformation will make primary health care more efficient; by focusing on prevention and health promotion, more people can receive care in the community rather than from hospitals and emergency rooms. This reduces costs for the system, and for families and individuals dealing with the personal costs of being ill.

As primary health care evolves in Alberta, people can expect that their care will include:

- Being attached to a primary health care provider or team;
- Having better access to care and more of that care delivered closer to home;
- Having the right provider available to meet their needs;
- One electronic health record that moves with them throughout their care journey;
- A focus on wellness and prevention;
- Programs and supports that help them manage their own health; and
- Health services that are integrated across communities and that are better connected to community and social services.

At a system level, people can expect that primary health care will involve:

- Community involvement in determining the best ways of meeting unmet local needs;
- An acknowledgement of the physical, mental, social, and spiritual dimensions of health;
- A focus on wellness and prevention at the system level;
- Effective information sharing that is used to improve care at the individual and system levels;
- A culture that values teamwork, innovation, continuous learning, and people participating in their own care; and
- Policy and programming across government that considers the impact on primary health care and minimizes unintended negative consequences.

6 For a complete list of comprehensive primary health care services, see Appendix Three.

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The Foundation for Primary Health Care in Alberta

When most people first think about health care, they think about doctors and hospitals. Yet primary health care, and the kinds of care and support available in the community, go beyond the clinic and local hospital.

Health services in the community include things like:

- Public health, which is delivered through 185 public health clinics across the province as well as through partnerships with communities, schools, and continuing care;
- Home care, which provides Albertans with a range of health and personal care services in their home or place of residence to support independence and quality of life; and
- Other services in the community, including those provided by Community Mental Health Clinics, dentists, community pharmacists, chiropractors, physiotherapists, psychologists, massage therapists, ophthalmologists, as well as family physicians who are not part of a formalized Primary Care Network or Family Care Clinic.

Furthermore, the entire health system is supported by health benefits such as prescription drugs, medical equipment and optical and dental services.

Primary health care in Alberta also includes a series of initiatives that have been implemented to help improve access to day-to-day health services. These initiatives, together with other aspects of the health system, provide a strong foundation for the ongoing evolution of the system. Some of these innovations include:

- **Primary Care Networks** (PCNs) have been established throughout the province to provide comprehensive primary care. First envisioned in 2003, there are now 41 PCNs in Alberta. Their staffing includes over 3,100 physicians and the equivalent of approximately 700 full-time positions for other health professionals such as nurse practitioners, nurses, dietitians, social workers, and pharmacists. PCNs were established to provide better access, greater health promotion and chronic disease management, improved care co-ordination, and increased use of interdisciplinary teams. PCNs are continuing to evolve to meet primary health care objectives.
- **Family Care Clinics** (FCCs) are team-based primary health care delivery organizations that provide individual and family-focused primary health care services tailored to meet the health needs of a community. FCCs provide non-emergency primary health care services. They also provide linkages to services that support early childhood development, mental health, and other issues such as homelessness, to address the needs of the community they serve. The clinics are expected to provide extended hours of service and same-day access. Teams may include family physicians, nurse practitioners, registered nurses, dietitians, pharmacists, social workers, psychologists, and others.

  In 2012, the first FCCs opened in Calgary, Edmonton, and Slave Lake. Another 24 communities were identified in June 2013 as having a high need for improved access to primary health care, as well as being ready and having the capacity to implement a FCC.

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Service Delivery

Primary health care services are currently delivered in a variety of settings, including: community ambulatory care centres; community health centres; community mental health clinics; Family Care Clinics; HealthLink Alberta; mental health and addiction services; MyHealth.Alberta.ca; Primary Care Networks; public health centres; stand-alone physician clinics; community pharmacies; university health centres; urgent care centres; and walk-in clinics.

- **Community Health Centres** (CHCs) are community-based organizations that provide a variety of primary health care services including primary care, education, health promotion, counselling, home care, and palliative care. These 148 centres are staffed by a variety of providers who may include health promotion facilitators, occupational therapists, physiotherapists, and registered dental hygienists. Most CHCs are operated by Alberta Health Services, while others are independently operated. In addition to directly providing services, CHCs provide assistance with navigating the health system, such as hospital discharge planning and co-ordinating continuing care placements.

  Some CHCs include Urgent Care Centres for people who have unexpected but non-life threatening health concerns such as broken bones, asthma, dehydration, and infections. These units have extended hours and are supported by laboratory and diagnostic imaging facilities.

- **HealthLink Alberta** is a province-wide health advice and information service staffed by registered nurses, other health care professionals, and non-clinical information and referral agents. HealthLink is available to all Albertans 24 hours a day, seven days a week, through telephone or internet. HealthLink Alberta provides symptom-based health advice (triaging), reliable general health information, and assistance in locating providers of needed health services.[7,8] HealthLink makes access to primary care services timelier and easier for many Albertans. Over 10 million calls have been made to the program since 2000.[9] HealthLink Alberta has contributed to a more knowledgeable public, fewer hospital visits, and healthier communities.[10]

24-HOUR INFORMATION

Anyone in Alberta with a health question or concern can call:

Toll-free: 1-866-408-5465
Edmonton: 780-408-5465
Calgary: 403-943-5465
Online: MyHealth.Alberta.ca

7 Letourneau, S. (2009). Health Link Alberta: A Model for Successful Health Service Integration. *Healthcare Quarterly*, 13. http://www.longwoods.com/content/21099.

8 Alberta Health Services (2013). *Health Link Alberta*. http://www.albertahealthservices.ca/223.asp.

9 *Ibid.*

10 *Ibid.*

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- **MyHealth.Alberta.ca** helps Albertans access reliable health information online and has been designed to become a health portal where people can access their own health information when that capacity becomes available in the future.

In the last decade, much has been learned about organizing and delivering primary care through these and other initiatives. We now have an opportunity to build on these learnings and move towards a broader, more integrated system of primary health care for Albertans. This strategy sets out a vision for this transformation, as well as three key strategic directions that describe how the transformation from primary care to primary health care will become a reality. These directions will be supported by an action plan and an evaluation framework.

Policy Linkages

The Primary Health Care Strategy is closely aligned and links with other policy initiatives underway, including:

- Alberta's Social Policy Framework
- Together We Raise Tomorrow
- Creating Connections: Alberta's Mental Health and Addiction Strategy
- The Alberta Tobacco Reduction Strategy
- Changing Our Future: Alberta's Cancer Plan to 2030
- Alberta's Health Research and Innovation Strategy
- Alberta's Strategic Approach to Wellness
- Early Childhood Development initiatives
- Collaborative Practice and Education Framework for Change

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Vision, Principles, and Outcomes

Vision

A primary health care system that supports Albertans to be as healthy as they can be.

This vision for primary health care in Alberta highlights several important ideas. It identifies the role of the primary health care system in supporting Albertans and speaks to the importance of people taking an active part in making decisions about and managing their health.

While providers and the health system at large play a critical role in supporting people and empowering them, the vision also recognizes that different individuals have different capacities for health — *as healthy as they can be* — and that the goal is to support each Albertan to achieve the best health possible. In this context, the term 'Albertans' includes individuals who may be in Alberta from other provinces or countries as workers, students, or visitors.

Guiding Principles

The guiding principles provide overall direction and indicate the key components of transforming to a primary health care system. These principles provide a framework to guide the work of the decision-makers, health care providers, and policy makers involved in primary health care. They are drawn from and align with the principles found in Alberta's

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Social Policy Framework. They also reflect the World Health Organization's definition of primary health care,[11] along with factors that are important in the Alberta context.

The principles are:

- **Person-Centred:** Primary health care provides services that reflect and respond to an individual's needs, culture, values, religion, language, and preferences. Individuals and their families are able to take responsibility for their health and an active role in decision-making about their health care.
- **Accessible:** The primary health care system provides all Albertans with a regular primary health care provider or team, and timely access to primary health care services through arrangements that facilitate 24-7 access to appropriate services. Services and programs are provided in a manner that is flexible and accessible to Albertans.
- **Sustainable:** Primary health care is delivered in ways that are effective, demonstrate value for money, and help ensure that the system is able to serve all Albertans.
- **Collaborative:** The primary health care system includes a range of providers, government ministries, the non-profit sector, citizens, and communities working together to improve the health of Albertans. Team members work at full scope of practice and with defined team roles and responsibilities in a culture of collaboration.
- **Proactive:** Primary health care services emphasize proactive approaches to prevention, health promotion, addressing root causes rather than symptoms, and focus on support for individuals that is close to home. A proactive approach involves Albertans in improving their health.
- **Continuity of Care:** The primary health care system is organized, connected, integrated, and co-ordinated with other parts of the health care system and with community and social services. Albertans are able to build and maintain relationships with their health care team.
- **Quality:** Primary health care strives for excellence, defined by the Health Quality Council of Alberta as acceptable, accessible, appropriate, effective, efficient, and safe. A quality health care system includes a focus on continuous learning and improvement from research and experience, evidence-informed decision-making, and individuals seeing the right provider at the right time.
- **Accountable:** Accountability is about people being empowered to take responsibility for their actions. At the system level it is reflected through good governance, sustainability, and reporting, and is mirrored by providers through their collaboration with peers and engagement with individuals.
- **Equitable:** Primary health care works to address issues of inequity that are barriers to health, particularly the health of vulnerable populations. Equity is about levelling the playing field for people. Good health outcomes are linked to people's social and economic situations, factors that can be modified through access to better health system supports, education, better incomes, and employment.

11 World Health Organization (1978). Report of the International Conference on Primary Health Care. http://whqlibdoc.who.int/publications/9241800011.pdf.

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Outcomes

As Alberta's primary health care system sets out to improve care, it will focus on the following outcomes:

- **Attachment** — all Albertans have a health home;
- **Access** — Albertans have timely access to a primary health care team;
- **Quality** — clinical and social supports are brought together to promote wellness, provide quality care based on proven courses of action, and effectively manage chronic disease;
- **Self-Management** — Albertans are involved in their care and have the supports needed to improve and manage their health;
- **Improvements in Health Status and Care Experience** — Albertans are as healthy as they can be, have better health overall, and report positive experiences with primary health care; and
- **Provider Engagement and Satisfaction** — providers are satisfied and happy with their work lives, and able to provide quality care.

Core indicators have been developed for each of the outcomes, including measures of timely access, improvement in health status, integrated approaches to assessing the quality of care, and supports for people with chronic diseases to self-manage their conditions. These will become the basis for measuring progress in implementing primary health care. For more details on measurement and evaluation, see Appendix Four.

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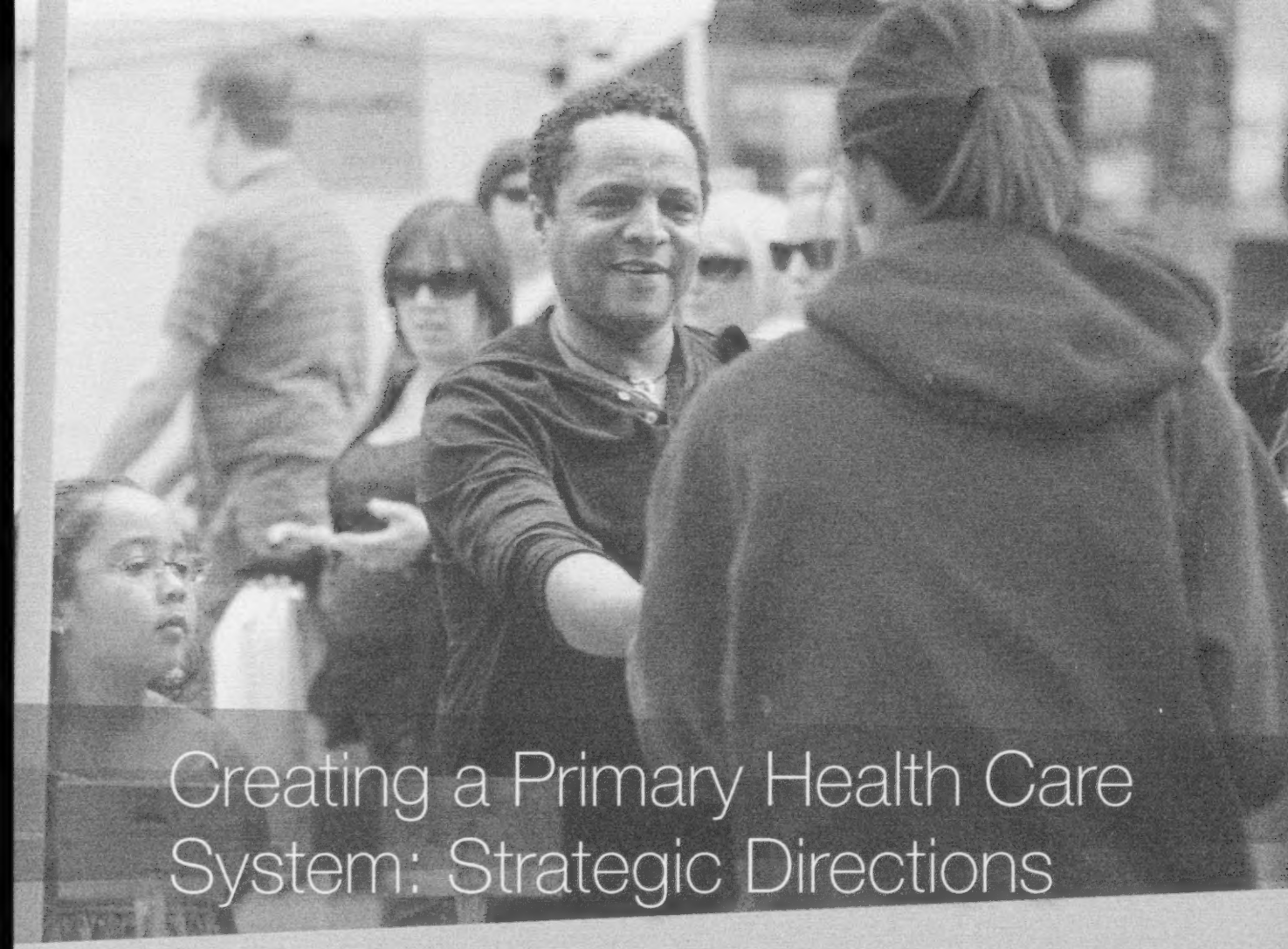

Creating a Primary Health Care System: Strategic Directions

This strategy is built around three strategic directions that will form the basis for the creation of a primary health care system:

- Enhancing the delivery of care;
- Cultural change; and
- Building blocks for change.

Each section involves a description of the strategic direction, followed by specific goals to achieve the vision for primary health care. An action plan will be developed to accompany the strategy in the coming months, which lays out the plans for implementing the recommendations and moving the primary health care system forward.

Strategic Direction 1: Enhancing the Delivery of Care

In Canada, primary health care has traditionally been one of the most loosely organized areas in health care. The types and levels of services available in communities has varied. In part to address this, primary health care reform in Alberta began in a concerted way in 2003 with the development of PCNs. However, many communities and populations remain underserved. As well, innovations have tended to spread slowly and there have not been agreed-upon standards for the delivery of care province-wide. Integrating services in ways that reflect how people use and need them remains a challenge in many areas, as does team work.

Enhancing the delivery of care requires action to provide every Albertan with a home in the primary health care system, establish clear expectations for care, and integrate and co-ordinate health and community services so primary health care is the hub of these services for Albertans.

Providing a Health Home

Health homes are a new concept in Alberta. For Albertans, a health home is essentially their 'home base' within the health care system, where they can access primary health care and be connected to the other health and social services that they need. In a health home, individuals have access to a core set of comprehensive primary health care services, delivered by a primary health care team.

There is no single model for a health home, and each one could have a somewhat different mix of providers and services that are appropriate for the individuals it serves. However, all health homes will play the same role for their patients. The health home is where people get primary health care services from a team, are connected with other services, and have their health care journey co-ordinated and managed.

One of the key features of having a health home is being attached to a provider or team. This means individuals have an ongoing relationship with their provider or team, which results in benefits for everyone. Having a consistent relationship means that providers know patients' histories, which reduces the number of times that people have to tell their story or undergo duplicate tests. This relationship also helps providers to better plan and coordinate care, and helps both individuals and providers understand and appreciate their obligations to each other. Evidence shows that individuals who are attached to a primary health care provider or team receive more preventive and chronic disease care, make fewer visits to the emergency room, are hospitalized less, and are more satisfied with the care they receive.

Goal 1. All Albertans will have a health home that provides:

a. Access to comprehensive primary health care services;
b. Attachment to a specific health care provider within a team or to a team of providers;
c. Care delivered through inter-disciplinary teams;
d. Care co-ordinated with other parts of the health system, such as specialists and home care; and
e. Effective connections with social services and supports, when needed.

What's different?

Goal 1. Creating a health home for all Albertans means:

- Albertans without a family doctor will be able to sign up to get a regular provider.
- Health homes will have teams of providers, such as:
  - Family doctors;
  - Nurse practitioners;
  - Registered nurses;
  - Pharmacists;
  - Psychologists; and
  - Social workers, etc.
- Clinics across the province will provide the same basket of services.
- Individuals will see the provider who best meets their needs.
- Access will be faster as appointments can be scheduled with any member of the health care team.
- The team will co-ordinate the individual's care with other parts of the health care system.
- Factors that impact an individual's health, like low income and poor housing, will be recognized and addressed more effectively.

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Comprehensive Primary Health Care Services

While services will be tailored to best meet the needs of the population or community being served, core primary health care service delivery includes:

- Health promotion and disease and injury prevention services;
- Addiction and mental health treatment and services;
- Seniors/geriatric care;
- Chronic disease prevention and management;
- Care of people with complex needs;
- Family planning and pregnancy counselling services;
- Maternal and child health services;
- Pediatric services;
- Ambulatory care and followup;
- Minor emergency care;
- Followup primary care;
- Rehabilitative care services; and
- Palliative and end-of-life care.

For further information, see Appendix Three.

Establishing Clear Expectations for Care Delivery

Clear expectations and requirements ensure that primary health care services are of the highest quality. In some instances these requirements are laid out in legislation or regulations, whereas in other instances expectations are established through policy or funding agreements. Health profession regulators set standards of practice, key competencies, and ethical requirements for their members. Information on existing standards and expectations in Alberta's primary health care system can be found in Appendix Seven.

These expectations include ensuring Albertans across the province have access to a common set of quality services that may vary in emphasis based on specific community needs. Expectations also provide assurances for providers that they are doing the right things and allow them to measure their performance. Requirements and expectations also help to assure individuals receiving services that the care they receive is the right care, and provide a way to understand what they can and should expect from their primary health care team and the primary health care system. Clear expectations can provide the tools to:

- Assure compliance with requirements set out by government, regulatory colleges and others;
- Facilitate quality improvement by highlighting what needs improving and how to carry out the improvements; and
- Shift practice and culture by setting out where existing practices should be moving based on evidence.

> "It is easy to get lost in the health system today, especially for seniors and those who find it hard to cope anyway."
>
> *Putting People First Consultation*

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> Every report we read is about beds, illness, mortality, morbidity…what does it mean to have measures of wellness? If we don't have measures of wellness, our hope of changing our focus is limited.
>
> *SWG*

What's different?

Goal 2. Establishing expectations for service delivery in primary health care means that:

- Albertans will be able to expect a common set of quality services across the province.
- The teams providing services will know how to work collaboratively.
- There will be regular public reporting on the effectiveness of primary health care services.
- No matter where an individual goes for primary health care, the provider will be able to see their medical record.

Implementing this goal will require working with providers provincewide to ensure they have the support they need. As well, health regulators and professional associations, Alberta Health, and other government ministries will need to work together to develop definitions and common requirements for care.

Goal 2. There are clear expectations for service delivery in primary health care. The expectations are that:

a. Clinical pathways are used to standardize care delivery across the province and set out how people with specific needs can more readily access services;
b. A national accreditation process is adopted to ensure consistency in quality;
c. Providers have the competencies and skills to operate in inter-disciplinary teams and integrate successfully with other health and social services;
d. Performance evaluation and reporting are used for continuous quality improvement; and
e. A single Information Management/Information Technology system is used for primary health care.

Integrating and Co-ordinating Services

Primary health care should be the hub for the co-ordinated delivery of health care and community and social services. While the relationship between social factors and health has been understood for some time, for the most part services continue to be delivered in separate streams. People have to navigate between the systems the best they can. At some point in their lives, all Albertans will need some social and community services for themselves or a loved one, particularly as they age. Shifting to make primary health care the hub of the health system will mean better and more seamless care, and providers working together and understanding an individual's overall situation.

Getting there requires integration and collaboration across the health system as well as with community and social services. In a collaborative environment, providers across programs and services join efforts to provide care. They share ownership over outcomes and they involve multiple providers in caring for individuals. While this type of integration requires significant team work, it also means that the team may include a wide range of providers located

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and integrated across communities — from those in a PCN or FCC to community health providers such as pharmacists and physiotherapists, to social service providers or supportive peer groups, to home care nurses and specialists.

Providers need to be open to new ideas, perspectives, and alternative solutions to challenges and problems. Collaborative efforts blend perspectives, expertise, resources, and accountability. For more background on integration, see Appendix Six.

The importance and difficulty of this shift need to be acknowledged; it will require changing the collective behaviours, attitudes, and mindsets of Albertans and providers. It will also take integration and collaboration within the health system at large so that connections between primary health care, community health services, specialized services, specialists, and hospitals are as seamless as possible for individuals and families.

Integration must be complemented by efforts to enhance the health and social service workforce. Although each community differs, gaps in services exist across the system, including access to services such as psychotherapy and other community addiction and mental health supports.

Goal 3: Primary care services are integrated with other parts of the health system and with social and community resources to create a primary health care system. This happens through:

a. Partnerships with home care, continuing care, public health, acute care, and specialists;
b. The use of leading practices to shape and improve integration;
c. Connecting with existing leading-edge social service centres;
d. Using "brokers" between health services and social and community services;
e. Continuously assessing community resources and assets; and
f. Removing the structural, policy, practice and attitudinal barriers to integration.

What's different?

Goal 3. Having an integrated health system means:

- Albertans will be able to expect a common set of quality services across the province.
- Avoiding duplicate testing and histories.
- Using each part of the health system more effectively.
- Making sure care is co-ordinated for individuals — they are not on their own.

Having a primary health care system that integrates with social and community services means:

- Primary health care clinics will be connected with Alberta Supports offices around the province.
- Health homes will help Albertans connect with the social services they need.
- Health providers will know the community resources available and use them.
- Community agencies will know what health programs are available to help their clients.

It doesn't help if people can see their family physician the same day but then have to wait six months to see a specialist.

SWG

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Strategic Direction 2: Cultural Change

Culture involves norms and expectations that individuals and providers have about how things are done. The culture of primary health care includes norms around who should provide what sort of care, the role of different members of a health care team and what say they should have within the team, where care should be provided, and the relative value of the contributions of different providers. The culture of primary health care also involves Albertans, who may have expectations about what provider they will see when they go to a clinic or the nature of their role in managing their own health.

The move from primary care to primary health care is in itself a culture change: it involves changing the way that we think about primary health care and broadening the concept of health to include the physical, mental and social aspects of health. Some other cultural shifts include:

- A move from tending to deal with people only once they become ill to a proactive system that focuses on wellness and prevention;

> We need to talk about an independence model instead of a dependency model. If providers are going to help people stay healthy, how do we support providers to provide those services?
>
> *SWG*

Alberta's Quality Matrix

The health system in Alberta is guided by Alberta's Quality Matrix for Health which defines six dimensions of quality:

- Acceptability: Health services are respectful and responsive to user needs, preferences and expectations;
- Accessibility: Health services are obtained in the most suitable setting in a reasonable time and distance;
- Appropriateness: Health services are relevant to user needs and are based on accepted or evidence-based practice;
- Effectiveness: Health services are provided based on identified knowledge to achieve desired outcomes;
- Efficiency: Resources are optimally used in achieving desired outcomes; and
- Safety: Mitigate risks to avoid unintended or harmful results.

Source: Health Quality Council of Alberta website

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- A change in how we think about primary health care in relation to acute and specialist care, recognizing the importance of primary health care as the foundation of the health care system; and
- An increased tolerance for taking on an appropriate level of risk. This includes the risk inherent in changing the delivery of primary health care, as well as the risk involved in giving individuals more control over their own care. This increased risk tolerance will support providers and individuals to develop new ways of interacting with one another and will allow individuals and teams to be more responsible for health outcomes.

Changing the culture in primary health care requires changing the collective behaviours, attitudes, and mindsets of both Albertans and providers. This is a complex process and will involve changes at all levels, from individuals to providers to the overall health system itself. Cultural change is a gradual process, and the recommendations below are designed to begin the process of changing how we think about, organize, and deliver primary health care services. The change process itself can also be challenging and as a result, change management strategies, structures, and leadership at all levels will be critical to successfully shifting the culture in primary health care.

> We should ask individuals what matters to them, not only 'what is the matter'?
>
> *SWG*

Encouraging and Supporting Albertans to Take an Active Role

One of the necessary major cultural shifts is engaging individuals as active participants in managing and making decisions about their own health. This shift also involves recognizing the important role people play when caregiving for other family members or friends. What constitutes active participation will be different from one person to another. Providers will need to balance people's preferred level of activity with an understanding of what this can mean for their care and health outcomes. Seeing patients as active participants involves not only changing the way that individuals think about themselves and their role within their own care, it also means changing the system so it is open to working with more active patients. For example, developing policies and systems that support individuals to communicate in new ways with their providers, such as by secure email or online patient records.

This cultural shift can be supported by others. Wellness programs in schools, businesses, and communities can encourage people to live a healthy lifestyle. Employers can reinforce the message to staff.

This shift is not only about Albertans taking a more active role in their health. It's also about providers getting accustomed to working with an active patient.

Goal 4: Albertans have the authority, knowledge, skills, and tools to take increased responsibility for their own health, and are supported as caregivers. This happens in a number of ways:

a. Individuals and providers work as equals in making care decisions;
b. Resources are available to support self-management and are tailored for different populations; and
c. Schools, universities, employers, and community organizations reinforce and contribute to this approach.

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What's different?

Goal 4. Supporting people to be active in their health means:

- Albertans will have the ability to interpret and act on the health information around them.
- Individuals will be partners in their health.
- Caregivers will be recognized as being part of the health team.
- Providers will be supportive, rather than directive partners in an individual's care.
- Tools such as MyHealth.Alberta.ca will support individuals' participation.
- Post-secondary students will be taught differently about the role of individuals in their own care.

Promoting Team-Based Care and Collaboration

There are many examples of successful team-based models in primary care in Alberta. However, in some clinics a culture persists where:

- Providers are possessive of their patients and reluctant to share responsibility and liability with other providers. Patients are seen by one provider even though other team members could address their concerns. Exclusiveness limits the ability to effectively leverage each provider's skills and abilities and does not optimize patient care;
- Communication that recognizes the contribution of every member of the primary health care team is often undervalued. Formal team communication and relationship building activities are not a priority. An individual's perception of the clinic may be based on their experience with the reception staff, the nurse, and the physician. But all these roles may not be valued by the clinic;
- Decision-making may not always include the perspectives of the full team; and
- Mistakes and negative experiences working with other providers can be over-emphasized and often, the response is to limit further interaction, not resolve the issues.

Providers need to view overlapping scopes of practice and teamwork as an opportunity to add value to their practices and each individual's experience, rather than as a competition. Well-functioning teams focus on maximizing the unique skills of each provider and optimizing each provider's role. Providers also need to view communication as an equally important part of their role and focus on building relationships and trust with each other.

Cultural competency is another important concept. There are two aspects to cultural competency. The first is ensuring that when providers from outside Alberta come to the province, they have the opportunity to learn the norms and expectations in Alberta's health system. The second is ensuring that providers have the background and tools to understand and adapt to the various cultures of individuals in an increasingly diverse Alberta.

> We lead the way in many things. Why is it we invent all these things and then lag behind?
>
> *SWG*

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Goal 5: Providers work in collaborative team-based models characterized by:

a. Shared responsibility;
b. An accountability to the team;
c. Knowledge of the capabilities of their peers; and
d. Enhanced cross-cultural competencies.

What's different?

Goal 5. Team-based care and collaboration means that:

- Providers will be more comfortable working together and will be accountable to each other.
- Providers will understand the many skills and capabilities of their peers and how to work together effectively.
- Providers that have come from other countries will have the supports they need to better understand and work in Alberta's health care system.
- Providers will understand the cultural diversity of Alberta and will be able to adapt to individuals' cultures.

> It's about turning what we know into what we do. We have gone as far as we can with the 'take really talented people and have them work harder and smarter' model.
>
> *SWG*

Fostering a Culture of Continuous Learning, Innovation, and Trust

At present, the primary health care culture tends to emphasize the importance of getting work done rather than looking for ways to improve service delivery. It also tends to emphasize finding fault and blame, which is a barrier to continuous learning, innovation, and trust. This lack of trust within the system can be found in the relationships between government and providers, among different professions and within professions, and between health system administration and providers.

The culture of primary health care needs to recognize that continuous learning, innovation, and trust are inextricably linked. Continuous learning requires the individual, team or organization to look for new ways of doing things and acknowledge that there may be value in other practices. Providers need to be able to trust that if they do just that, their competency won't be in question. Innovation requires a tolerance for managed risk and the willingness to learn new approaches. Trust and trustworthiness are parts of an innovative learning culture, as are accountability and transparency.

Ways need to be found to change the culture and encourage discussions regarding what is and isn't working well. A strong culture of innovation can be fostered through effective leaders and champions at all levels, who inspire and empower individuals to make changes and adopt an improvement and innovation mindset in their work. The primary health care system and its administrators need to emphasize knowledge translation, adoption, and implementation more strongly.

Innovation can be about finding new ways of doing things, as well as about sharing and adopting new ideas. In primary health care, innovation should be seen as a means of delivering better care and meeting requirements and expectations. Innovation should always be linked with ways of sharing successes and supporting the adoption of new ways of doing things.

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Demonstration and pilot projects should include adoption and implementation strategies to ensure commitment at the system level to systematically spread successes, so that there is continued support and expansion of things that are working well. This includes investing in change management strategies that focus on replacing traditional behaviours with new or improved behaviours. From a system perspective, resources invested in measuring what is occurring need to be complemented with investments in quality improvement and change. For additional information, see Appendix Five.

Goal 6: Primary health care supports continuous learning, innovation, and an increased tolerance of risk by:

a. Supporting formal and informal leaders to be change champions;
b. Transitioning successful pilot projects into operational programs; and
c. Using a centre of excellence approach to share successful innovations and practices.

What's different?

Goal 6. A culture of continuous learning, innovation, and trust means that:

- Resources will be dedicated to supporting change management.
- Good ideas will be shared with others and adopted across the province.
- Evaluation will routinely help to identify successful innovations and practices.

Developing a Greater Understanding of the Social Determinants of Health

Evidence indicates that many differences in health status result from differences in what people experience in their lives, for example social and living conditions.[12] Across society, individuals with lower socioeconomic status tend to have poorer health outcomes.

These differences between population groups are referred to as health inequities. Health inequities occur as a result of systemic social and economic conditions and practices that create barriers to opportunity. These differences in the distribution of the determinants of health such as income, housing, and education undermine the health of certain groups within the population.

Health inequities are more pronounced among children and families living in poverty, the working poor, individuals living in rural or remote areas, people who are unemployed/under-employed, those with limited education and/or low literacy, Aboriginal populations, new immigrants, the homeless, and people with addictions and/or mental illness. The impact of poor health, lost potential, and financial costs to individuals, families, and society is substantial.

Generally speaking, it is known that health inequities are a problem and that the social determinants of health contribute to the health status of a population. However, it's not clear to what extent providers should take these into account, or even how to do so. A shift is needed to learn about the impact of health inequities and find solutions that work. The shift will largely be made at the clinic level, but the Government of Alberta also has a role to play.

12 Population Health Promotion Expert Group (2008). *Closing the Health Gap: Synthesis of the Significant Population Health Reports of 2008*. Ottawa, Ontario: Pan-Canadian Health Network.

Goal 7: Primary health care will positively influence the root causes of health inequities by:

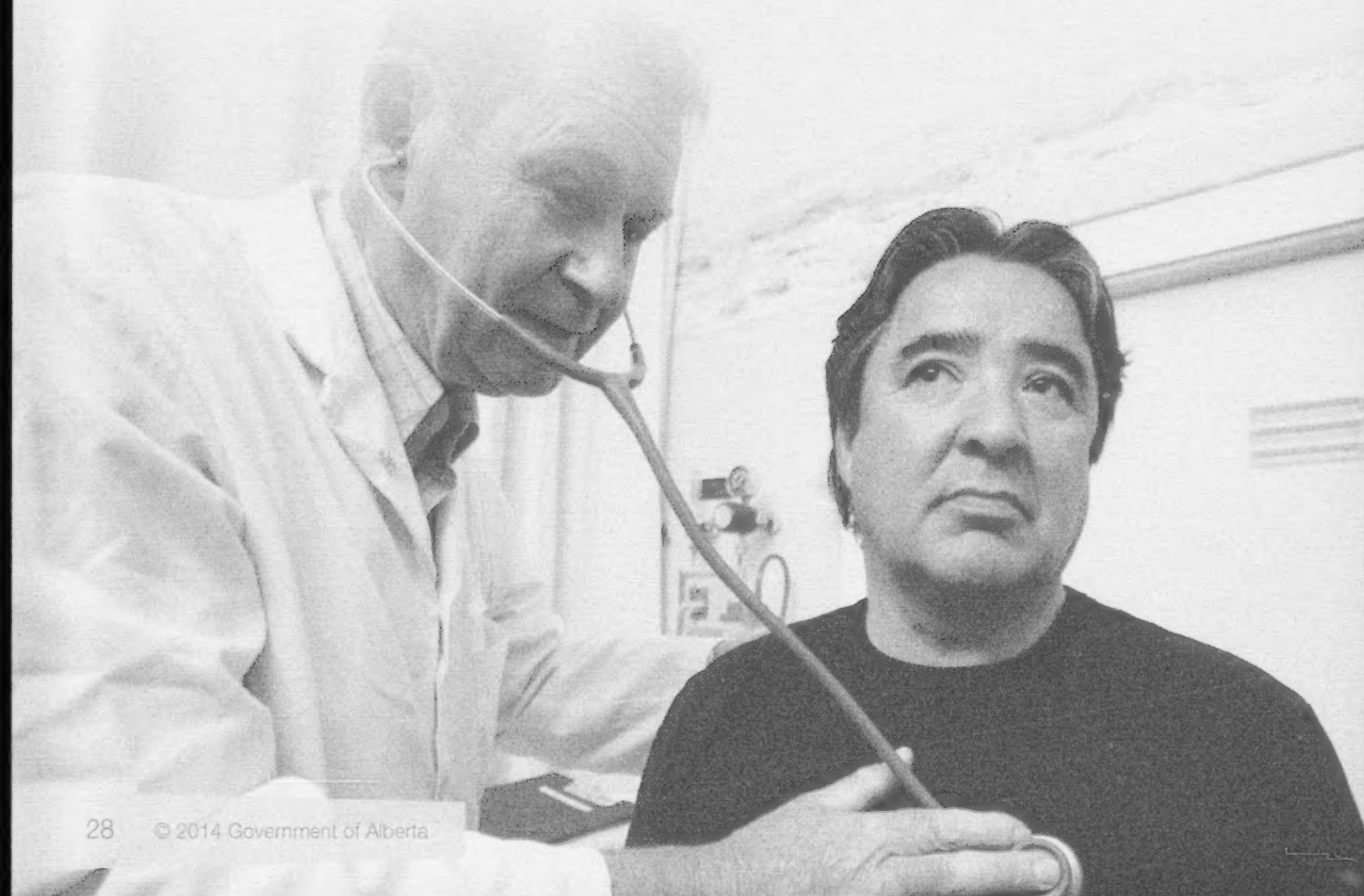
a. Leveraging cross-ministry and cross-sector initiatives; and

b. Enhancing provider education and competencies about the social determinants of health.

What's different?

Goal 7. Understanding the social determinants of health means that:

- GOA ministries will combine forces to support communities in identifying resources and needs.
- Ministries of Health, Education, and Human Services will align policies, integrate service delivery, share community engagement, and make sure everyone is on the same page.
- Professional development about root causes of health inequities will be available for providers.



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Strategic Direction 3: Building Blocks for Change

In addition to the first two strategic directions, there are other key components needed to form the foundation for primary health care transformation. These include: governance; funding models; available information management systems; and the primary health care workforce. While these may not be as visible as some of the delivery-level changes, they are fundamental to achieving the vision for primary health care.

Governance to Create an Effective Primary Health Care System

There are many checks and balances within primary health care. Boards govern each PCN and FCC, and each network or clinic must follow rules set out in funding agreements set by Alberta Health. Partnership agreements with Alberta Health Services create another set of expectations. Professional colleges regulate groups of providers. Each of these layers plays a role in establishing accountabilities. But they do not create a primary health care "system." And they do not co-ordinate the provision of primary health care across geographic areas of the province. Co-ordination at a geographic level is needed to plan and meet community needs.

In order to make the shifts set out in this strategy, there needs to be a governance structure to fill in the gaps. Some entity needs to say what will be worked on first, needs to gather resources, and needs to provide overall leadership.

This strategy will be accompanied by an action plan that sets out the steps needed to achieve these goals. As a first step, a committee should be created to carry on the work of the strategy working group. The committee would oversee and guide the implementation of the strategy and action plan.

Goal 8: Structures are needed to develop primary health care into a system. To start:

a. Establish a committee to oversee and guide the implementation of the strategy and action plan; and

b. Establish a mechanism that uses geographic boundaries to co-ordinate the provision of primary health care in those areas.

What's different?

Goal 8. Creating a primary health care system means:

- Clinics and providers will have a place to turn to for leadership.
- Gaps will be identified and resources directed to fill those gaps.
- Responsibility for leading implementation of the Strategy will be clearly assigned.

Implementing Compensation Models that Support Innovation and Team-Based Care

Compensation models directly influence provider behaviour and impact the successful adoption of service delivery innovations and improvements. While it has long been argued that fee for service models are a barrier to innovation, they remain the dominant way in which physicians are compensated. This in turn has impacted how care is organized among other providers in the primary health care teams working with physicians.

Ultimately, compensation models should be flexible, sustainable, and provide incentives for improvement. They need to support innovative delivery models and team-based care. Cost effectiveness and economies of scale are additional considerations for alternative funding models.

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Compensation is one of several levers that can be used to reinforce the importance of achieving outcomes for populations served. It should be considered alongside other factors that motivate organizations to work together, within a broader context of who they are serving what the needs are, and what outcomes they hope to achieve. Health care professionals and organizations want to provide quality care to Albertans; therefore it is the system's responsibility to remove barriers, of which compensation models are only one, that inhibit collaborative practice and team-based care.

It is also important to note that any changes to compensation models and contracting practices must be accompanied by information systems and other supports to effectively manage such a transition.

Goal 9: Provider compensation is aligned with the new approach to primary health care delivery by:

a. Developing compensation models that are flexible, sustainable, and improve service delivery to Albertans;
b. Examining compensation models, including fee for service, to determine the most appropriate ways of compensating providers to support primary health care; and
c. Reviewing compensation models to ensure fair and equitable compensation for all providers in primary health care.

What's different?

Goal 9. Supportive compensation models mean:

- Providers will have the time to see individuals for more than one complaint.
- Providers will be enabled to work in a collaborative team-based environment.
- Different ways of delivering care will be supported — for example, case conferencing or phone calls to provide test results.

> We shouldn't be afraid of getting rid of things that aren't working.
>
> *Primary Health Care Expert Advisory Group Member*

Putting in Place Common Information Management and Information Technology

Information sharing and information management/technology (IM/IT) are the backbone of team-based care and integration within the health system and with social and community services. IM/IT is also a critical enabler of innovation and monitoring progress on guidelines and standards.

Primary health care has an integral role to play in implementing a single electronic medical record (EMR) for each Albertan. EMRs are the basis for a health home and for ensuring individuals and primary health care providers have access to necessary information when and where it is needed. The EMR also allows relevant information to be shared effectively with other providers and sectors.

The *Health Information Act* contains important provisions on how information is handled, but it also places limits on information sharing within the health system and with social service providers. Work has been undertaken within the Government of Alberta to address these issues and needs to continue to receive support. The emphasis should be on enabling sharing, when necessary, rather than removing all risk.

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Goal 10: Primary health care uses a single Information Management/Information Technology (IM/IT) system. The single system:

a. Uses a single medical record for primary health care patients;
b. Enables communication, co-ordination, and information management across providers; and
c. Allows reporting, performance evaluation, and clinical statistics for clinic and system management.

What's different?

Goal 10. Using common IM/IT systems means that:

- Providers will be able to review and add to a patient's medical record.
- Albertans won't have to repeat their stories or undergo duplicate tests.
- All team members will base their treatment decisions on the same information.
- Providers, clinics, and systems will have the data needed to measure and report performance to improve outcomes.

Developing and Supporting the Primary Health Care Workforce

The primary health care workforce, including health, social, and community service providers and administrators, forms the foundation of primary health care delivery. To deliver quality care, it is essential to ensure the appropriate providers are available and that they have the supports they need. Workforce planning needs to take into account the shifts in how primary health care is delivered.

Moving to the desired primary health care system means changes in how providers carry out their responsibilities. Change is difficult and will not happen without concerted efforts and support. This includes the development of change strategies around all aspects of the Primary Health Care Strategy. This work is needed to contribute to provider satisfaction.

Some of the work in supporting change should be done through centres of excellence and communities of practice. These change strategies are already emerging in parts of the province and should be supported at the system level.

Goal 11: The primary health care workforce has the skills, competencies, and resources to support the primary health care transition. This happens through:

a. Post-secondary training;
b. Professional development; and
c. Change management programs.

What's different?

Goal 11. Workforce development means that:

- Providers will have the supports they need to make the shifts outlined in the strategy.
- Resources will be in place to support these changes.
- We will recognize that providers can't do this on the corner of their desks.
- Post-secondary education will align with the goals of primary health care.
- Professional development will be available to help those already practising.

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Involving the Community and Being Responsive to Local Needs

Communities have a profound influence on overall health and well-being. Involving the community in planning and delivering services will strengthen the primary health care system. An ongoing dialogue with a community should lead to services that meet local needs. These relationships and open and transparent sharing of ideas and feedback are critical to ensuring that unmet needs are identified and addressed.

Building a person-centred system also requires more meaningful citizen involvement in health system design. Soliciting and incorporating people's feedback on care planning and service design will help providers and clinics to better understand what matters to individuals beyond the care itself (including non-clinical components like staff friendliness or accessible parking). This understanding will, in turn, ensure that services better match what individuals need.

Goal 12: Communities and individuals are key players in primary health care system planning and design, through:

a. Community representation on advisory and governance boards; and

b. Engaging individuals to make care more person-centred.

What's different?

Goal 12. Responding to local needs means that:

- Primary health care services will be based on the needs of communities.
- Communities will work together to address issues faced by at-risk populations.
- Patients will have a say in a system that is designed around them.

Communicating About Primary Health Care

Transforming primary health care requires more than a series of initiatives and projects; it's about creating a movement. Getting that movement started means the message needs to get out — in order to achieve the vision for primary health care, we need to tell people where we are heading. The first step is communicating with Albertans and providers about what a primary health care transformation is, what it means, and why it is important. However, communication can't stop there: it has to be ongoing communication that changes as primary health care evolves.

Communication isn't a one-way street. Albertans, providers, and policy-makers need ways to talk to each other about what's happening. This transformation of primary health care is a new path, and we know that we will encounter new challenges and need to rely on each other to solve problems. On top of this, providers are being asked to do many things differently and need a way to discuss ideas, solve problems, and share best practices.

Goal 13: Communication channels and tools are in place to support the primary health care transition. These include:

a. Effectively communicating with Albertans and providers about the primary health care transformation; and

b. Establishing a forum for primary health care discussions, information sharing, and disseminating best practices and resources.

What's different?

Goal 13. Good communication means that:

- The message will be communicated frequently and in many formats.
- Communication will be two-way.
- There will be a dialogue: feedback receives a response.

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Evaluating Effectiveness

Change and quality improvement processes need to be anchored by clear ways to determine the effectiveness of care delivery. A robust primary health care evaluation framework has been developed that includes a logic model to frame Alberta's primary health care system as a whole. The framework also recognizes the different approaches being taken to improve primary health care delivery (see Appendix Four).

To ensure that the desired outcomes are achieved, the outputs of the system will be measured. These include numbers of people enrolled with a health home, service volumes and types of services, number of service-integrated referrals, and other activities that can be counted. System outcomes that will also be measured include: improved primary health care access; greater attachment; higher quality family and person-centred care; improved health outcomes; improved care experience; healthier choices and behaviour; greater efficiency; and more accountability. These system outcomes are aligned with the Triple Aim approach[13] that targets better health, better care, and better value.

Goal 14: The primary health care evaluation framework is used to:

a. Support continuous improvement;
b. Measure effectiveness;
c. Improve quality of care; and
d. Inform best practices.

What's different?

Goal 14. Evaluation means that:

- We can see how we're doing.
- We can report publicly on primary health care.
- Primary health care is accountable.
- We know what the best practices are.
- We can identify and implement improvements in quality and patient safety.

> We don't have a 'health system'. We work in silos and don't share information or benefit from the feedback loops that make people successful.
>
> *SWG*

13 Institute for Health Improvement (2013). *The IHI Triple Aim Initiative.* http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx.

Moving Forward

Over the last decade, a wide variety of initiatives and innovations have created a solid foundation for Alberta's primary health care system. As we move forward, we will build on this foundation and continue to promote innovative models of primary health care. Successful primary health care transformation on this scale will require time. The 14 goals described in this strategy show where we are ultimately going with primary health care. The next step is to develop a detailed action plan that will set out how we are going to make these shifts a reality. Guided by the vision and principles laid out in the strategy and following the action plan, we will continue to work towards a primary health care system that can provide accessible, high-quality primary health care services for all Albertans.

Appendices

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Appendix Six	Integration
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Appendix One — Contributors

Work on Alberta's Primary Health Care Strategy has its genesis in years of work on primary care and primary health care, including work on Primary Care Networks, Family Care Clinics, and the integration of services that has been underway in the larger health system. A concerted effort to bring together various initiatives and plans into a Primary Health Care Strategy began in earnest during fall 2012 with the establishment of the Primary Health Care Strategy Working Group and the Minister's Advisory Committee on Primary Health Care.

Appreciation and thanks goes to the following people who devoted considerable time and energy to making this strategy a reality.

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Appendix Two — Strategy Highlights

Primary Health Care Strategy

Vision

A primary health care system that supports Albertans to be as healthy as they can be

Guiding Principles

Person-Centred

Primary health care provides services that reflect and respond to an individual's needs, culture, values, religion, language, and preferences. Individuals and their families are supported and encouraged to take responsibility for their health and an active role in decision-making about their health care.

Accessible

The primary health care system provides all Albertans with access to a regular primary health care provider or team, and timely access to primary health care services through arrangements that facilitate 24-7 access to appropriate services. Services and programs are provided in a manner that is flexible and accessible to Albertans.

Continuity of Care

The primary health care system is organized, connected, integrated, and co-ordinated with other parts of the health care system and with community and social services. Albertans are able to build and maintain relationships with their health care team.

Proactive

Primary health care services emphasize proactive approaches to early prevention, health promotion, addressing root causes rather than symptoms, and focus on support for individuals that is close to home. A proactive approach involves Albertans in improving their health.

Collaborative

The primary health care system includes a range of providers, government ministries, the non-profit sector, citizens, and communities working together to improve the health of Albertans. Team members work at full scope of practice and with defined team roles and responsibilities in a culture of collaboration.

Accountable

Accountability is about people being empowered to take responsibility for their actions. At the system level it is reflected through good governance, sustainability, and reporting, and is mirrored by providers through their collaboration with peers and engagement with individuals.

Sustainable

Primary health care is delivered in ways that are effective and demonstrate value for money and help ensure that the system is able to serve all Albertans.

Quality

Primary health care strives for excellence, defined by the Health Quality Council of Alberta as acceptable, accessible, appropriate, effective, efficient, and safe. A quality health care system includes a focus on continuous learning and improvement from research and experience, evidence-informed decision making, and individuals seeing the right provider at the right time.

Equitable

Primary health care works to address issues of inequity that are barriers to health, particularly the health of vulnerable populations. Equity is about levelling the playing field for people. Good health outcomes are linked to people's social and economic situations, factors that can be modified through access to better health system supports, education, better incomes and employment.

Outcomes

Attachment

All Albertans have a health home.

Quality

Clinical and social supports are brought together to promote wellness, provide quality care based on proven courses of action, and effectively manage chronic disease.

Self-Management

Albertans are involved in their care and have the supports needed to improve and manage their health.

Access

Albertans have timely access to a primary health care team.

Improvement in Health Status and Care Experience

Albertans are as healthy as they can be, have better health overall, and report positive experiences with primary health care.

Provider Engagement and Satisfaction

Providers are satisfied and happy with their work lives, and able to provide quality care.

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Transforming the Primary Health Care System: Strategic Directions

Enhancing the Delivery of Care

What it Means For Albertans

Albertans without a family doctor will be able to sign up to get a regular provider and will see the provider who best meets their needs. Access will be faster because appointments can be scheduled with any member of the health care team. The team will make sure care is co-ordinated for individuals — they will not be on their own.

What it Means For Providers

Working to enhance the delivery of care, providers will work collaboratively across occupational silos and will provide their patients with a broad range of care. With a greater understanding of who their patients are, primary health care teams will be able to better tailor their services to meet the needs of their local communities. Providers will understand the many skills and capabilities of their peers and how to work together effectively.

Cultural Change

What it Means For Albertans

Cultural change is about changing the way we see and think about our health and health care. Albertans will be supported to be active in their health and will have the ability to interpret and act on the health information around them. Albertans will be partners in their health care and tools such as myhealth.ca will support an individual's participation.

What it Means For Providers

Cultural change will happen in a variety of ways, such as new and strengthened linkages to community and social services. Providers have long understood the impact of the social determinants of health, and now connecting patients with the supports they need will be made easier. Professional development will be available for providers to learn more about the root causes of health inequities.

Building Blocks for Change

What it Means For Albertans

Building blocks for change is about changing the way primary health care is organized, particularly at the system level. For Albertans, these changes will be seen in all sorts of ways when accessing primary health care — such as not having to repeat their stories or undergo duplicate testing. Patients will be involved in building change and will have a say in a system that is designed around them.

What it Means For Providers

Building blocks for change are ways providers can be supported to help transform the system. One of the most visible building blocks will be a common IM/IT system that allows for easy communication across providers and organizations. All team members will be able to base their treatment decisions on the same information, and providers and clinics will have the data needed to measure and report performance to improve outcomes.

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Appendix Three — Comprehensive Primary Health Care Services

The following is a description of the core primary health care services that would be available to Albertans through their home in the health system.

Health promotion and disease and injury prevention

- Screening of individuals at risk to prevent disease or to allow for early detection, intervention, and counselling to reduce risk
- Access to immunization services and programs
- Periodic health assessments
- Organized population health screening and health promotion
- Development and implementation of health promotion and injury prevention programs

Addiction and mental health services

- Early identification and treatment of addiction and mental health problems, including mental health screening and diagnostic interviews
- Mental health and addictions counselling and services for individuals and families, which may include psychotherapy
- Assistance to individuals and their families to navigate the system
- Crisis support services
- Education to encourage individuals and families to make healthy lifestyle choices that will contribute to maintaining good mental health
- Counselling services for families of catastrophically or terminally ill individuals
- Counselling services for family members of clients with chronic diseases or conditions

Seniors/geriatric care

- Basic ambulatory care and followup tailored to seniors/geriatric needs
- Counselling and supports focused on the unique needs of seniors and their families
- Services to support "aging in place"

Chronic disease prevention and management

- Proactive screening
- Ambulatory care and followup for clients with chronic conditions
- Chronic disease management services in collaboration with a community-based service delivery framework that includes health promotion, prevention, early detection, and primary treatment

Population health improvement

- Delivery of programs and services that address the needs of populations or sub-populations, and the factors that contribute to, and determine, health status
- Establishment of links and partnerships with community-based services to provide social supports for individuals and families

Individual and family engagement

- Capacity building to support client self-management
- Design and implementation of programs and approaches to effectively engage individuals and families in planning for, and taking accountability for, their health

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Care of individuals with complex needs

- Assessment, diagnosis, management, and followup for complex health concerns
- Opportunistic prevention and health promotion services

Family planning and pregnancy counselling services

- Counselling for birth control and family planning
- Education, screening for, and treatment of sexually transmitted infections

Maternal and child health services

- Antenatal care to term services
- Postpartum maternal and newborn care
- Well-child care services
- Screening, parent education, and counselling regarding infant/child health and development

Ambulatory care and followup

- Assessment, diagnosis, management, and followup of simple episodic health concerns
- Routine, periodic health assessments
- Opportunistic prevention and health promotion services
- Minor surgery — treatment and followup

Minor emergency care

- Minor emergency care including conditions relating to age, distress, or potential for deterioration, or complications that would benefit from intervention or reassurance within one to two hours

Followup primary care

- Support and/or provision of primary care to clients in hospitals and continuing care facilities where appropriate
- Discharge planning and out-patient followup services; e.g., linkages to home care, rehabilitation

Rehabilitative care services

- Provision of, or links to, community rehabilitative services such as physical therapy, occupational therapy, speech language pathology, audiology and respiratory therapy

Palliative and end-of-life care

- Basic ambulatory care supports and followup
- Access to medical supplies, medications, and supportive practical equipment based on assessed needs
- Pain and symptom assessment and management
- Home visits and access to supports for caregivers
- Links and timely co-ordination with other service providers
- Access to palliative care specialist consultation
- Advanced care directives and planning options for patients identified as palliative

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Appendix Four — Evaluation Framework

Primary health care is a system within the broader provincial health care system. Establishing clear outcomes for the primary health care system and ensuring that the system is delivering quality care is no small task. To support assessment and evaluation of primary health care in Alberta, an evaluation framework has been developed.

The framework contains components that can be used to evaluate different aspects of primary health care delivery models. These include a logic model, core evaluation questions, a menu of performance measures and indicators, and a description of the five key evaluation activities supported by the framework.

The framework itself is not an accountability or evaluation plan. It is a reference document that provides tools for conducting formal and informal evaluations. The framework also aligns with and supports the provincial government's Results-Based Budgeting process and Health Systems Outcomes and Measurement Framework.

A number of overarching questions were identified during the development of the evaluation framework. At a high level, they include asking: do Albertans have improved access to primary health care? Are they attached to a regular provider or team? Are they receiving quality care? Other questions look more closely at the care experience, including whether health outcomes have improved, the quality of individuals' experiences, and whether people are making healthier choices and reducing high-risk behaviour. Another group includes system questions: Is the system becoming more efficient? Does it have the workforce it needs? Is there more accountability?

As the framework is implemented, it is expected that key areas for evaluation activities will include contract management requirements, performance monitoring at individual sites and at the system level, assessing the effectiveness of system and model level enablers, in-depth evaluation of aspects of models of care, and the evaluation of system level outcomes and model comparisons.

Logic Model

The framework includes a logic model that encompasses all aspects of the primary health care system and demonstrates how they fit together. This forms the foundation for understanding and assessing primary health care. The logic model lays out the elements that must be in place in order for change to occur. It also addresses service delivery and itemizes activities — the 'what' and 'how' of primary health care. The outcomes are the results, including improved access, greater attachment, increased quality of care, improved health outcomes, a better care experience, healthier choices being made by people, and more efficiency and accountability throughout the system. These are similar to the outcomes set out within the Primary Health Care Strategy and as work proceeds, it is expected that terminology and underlying definitions will be aligned with one another.

For further information, visit the Primary Health Care website at health.alberta.ca/services/primary-health-care.html.

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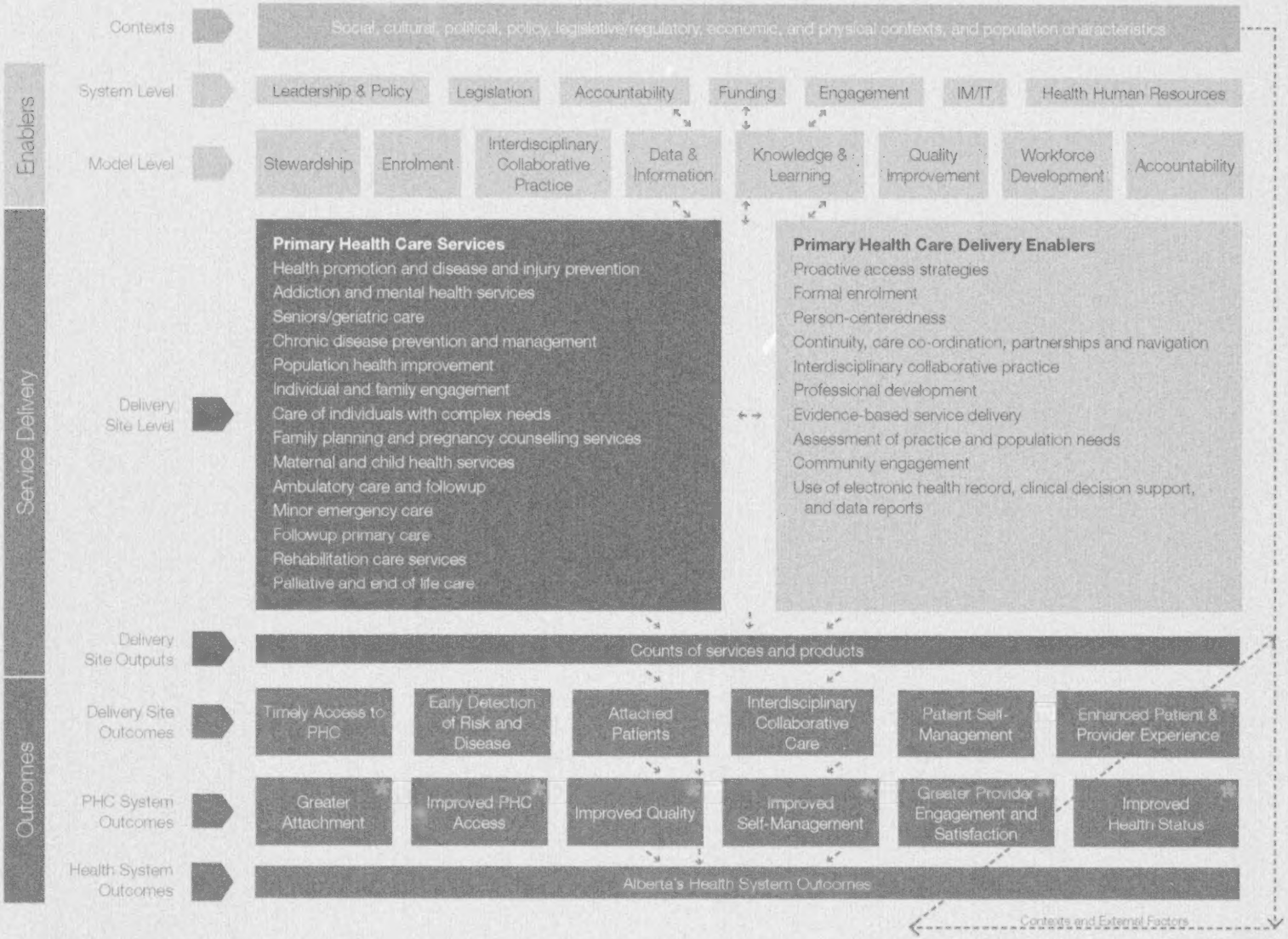
Logic Model for Alberta's Primary Health Care System



* These outcomes match those listed in the Primary Health Care Strategy

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Appendix Five — Innovation

The magnitude of change involved in transforming the primary health care system cannot be overestimated. Throughout the province, health care providers, social and community organizations and individuals are going to need to learn new ways of working together. Some of these ways of working are already known and can be learned from others, but others will need to be developed and tested to see if they work in all settings, all communities, and with all populations. Building a system where everyone is encouraged to innovate and find new ways of doing things will require direction, time, and resources.

There are a number of strategies with the potential to support and accelerate successful innovation. Two key strategies are centres of excellence and communities of practice. An additional strategy that focuses on supporting grassroots innovation is a 'communities of solution' approach where all relevant organizations and providers in the community are involved to define, deal with, and solve local health issues. Patient panels are valuable to identify areas where services can be redesigned to make them more person-centred.

At a system level, innovation can be supported through:

- **Networking forums:** Many of these types of forums already exist (e.g., conferences), which provide opportunities for providers and organizations to make connections and share ideas. These types of forums can also be used to increase participation in centres of excellence and communities of practice;
- **Online resources:** A centralized online resource can help enable the spread of ideas, facilitate knowledge transfer and sharing across providers, and provide a means to identify appropriate leaders and champions;
- **Facilitation supports:** External facilitation is a critical success factor for the sharing of best practices. This could be supported by an independent, non-partisan organization with a mandate to facilitate the adoption of best practices, ensure objectivity, and facilitate provider buy-in and uptake;
- **Identifying formal and informal leaders:** Formal leaders and champions can be identified and enabled through a centres of excellence approach. Informal leaders and champions can also be identified and supported at the grassroots level, as they have a more direct role in engaging service providers and organizations; and
- **Change management:** this includes strategies, structures, and leadership designed to facilitate and support large scale organizational change.

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Appendix Six — Integration

Some key points that are relevant when discussing integration include:

- Integrated care takes many different forms. This can include integration between primary and other levels of care, as well as between health services and social and community services;
- A distinction can be drawn between "real" integration, in which organizations merge their services, and "virtual" integration, in which providers co-ordinate and work together through networks;
- Both real and virtual integration may take place among providers operating at the same level, often referred to as "horizontal" integration, and among providers working at different levels, known as "vertical" integration; and
- Integration will not deliver benefits if providers do not change the way they work.

Components of Integration

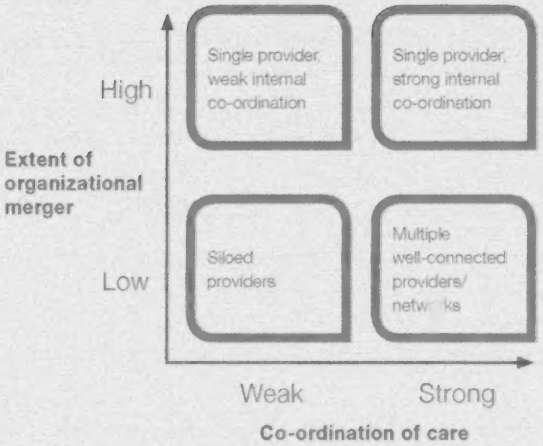
To achieve integration, different mechanisms are used at various levels of the system. Integration can be seen at the macro, meso, and micro levels.

Macro-level Integration

Macro-level integration involves providers delivering integrated care across the full spectrum of services to the populations they serve. Some key features of macro-level integration include multispecialty provider groups, aligned financial incentives, shared information technology, responsibility for defined populations, and a collaborative culture.

Meso-level Integration

Meso-level integration focuses on care for particular patient groups and populations, whether they are classified by age, condition, or some other characteristic. A common way to co-ordinate and integrate care for patients and populations with specific conditions has been to link primary care,



acute care, and community care through care pathways, based on local agreements between providers. A typical pathway might include screening in a primary care centre and treatment at a specialist clinic at the local hospital, followed by rehabilitation provided in the community.

Micro-level Integration

Micro-level integration is concerned with the co-ordination of care for individual patients and support for providers (family members or others). Many health care systems assign responsibility for care co-ordination to a specific individual or team from primary care, often with nursing or other clinical expertise. This type of integration can involve a variety of tools and strategies, such as:

- Care planning and use of case managers;
- Virtual wards, in which integrated teams support patients with complex needs in the community;
- EMRs and other information technology, to enable patients and providers to access information; and
- Telehealth and telecare to help patients live independently and minimize the travel required.

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Appendix Seven — Primary Health Care Standards in Alberta

While physicians, nurses, and other clinical staff in primary health care have been subject to professional competency and licensing standards for many years, inspection and accreditation of clinics and other primary health care delivery sites has been less frequent and less stringent than comparable practices in the acute or continuing care sectors. However, there has been movement during the last decade toward a more standards-based approach, and adoption of evidence-based guidelines. Beginning in 2003, some of the key initiatives in this area have been:

- The Primary Care Initiative, under which 41 PCNs have been established, approved, funded and governed. PCNs, which now deliver primary care to over 80 per cent of Albertans, have documented governance models and standardized business plans and work collaboratively with AHS on a number of measurement and quality improvement initiatives;
- The Toward Optimized Practice (TOP) initiative, which publishes a continuously-expanding set of evidence-based Clinical Practice Guidelines, many of which apply to primary care;
- The Access Improvement Measures (AIM) initiative, which works with providers to apply continuous learning and measurement approaches to develop measures that can enhance access, efficiency, and staff morale;
- The more recent Family Care Clinic (FCC) program, which will establish a new set of primary health care delivery sites that will adhere to requirements for governance, service delivery, funding, and other factors; and
- The Health Quality Council of Alberta, which has played a key role in this evolution through its work, including publication of a Quality Matrix and collection of standardized data on many aspects of health care.

Current Use of Standards in Alberta

There are numerous examples of standards that are currently used in Alberta, including:

- The College of Physicians and Surgeons of Alberta, the College and Association of Registered Nurses of Alberta, and other colleges/associations that license providers each establish their own standards. These include requirements for educational credentials and continuing professional education, ethical conduct guidelines, and standards of practice;
- As a condition of initial approval and ongoing support, PCNs are obliged to adopt and document certain governance models, produce and periodically update business plans, and submit standardized reports to Alberta Health and AHS;
- The FCC Reference Manual contains numerous standards and guidelines for how FCCs should operate and deliver services;
- The Accreditation Canada Standards for Primary Care Systems include a structured set of criteria that can be used to accredit primary health care practices;
- AHS has fostered several Strategic Clinical Networks (SCNs), whose mission includes defining and encouraging the use of best practices in selected clinical areas (e.g., bone and joint health, cardiovascular health and stroke). These may be considered an input into standards. However, to date, primary health care has not been a focus of SCNs; and
- The Health Information Standards Committee for Alberta (HISCA) approves and monitors the application of numerous standards related to health information management and communication in the province.

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Guiding Principles for Standards

Discussions to develop the strategy resulted in a series of guiding principles for developing and implementing the standards needed to support a person-centred approach to primary health care. These include:

- Examining the need for standards in the context of primary health care, not just primary care;
- Supporting providers and organizations in implementing standards;
- Providing feedback to individuals and/or organizations about how they are performing relative to standards;
- Defining and communicating the relationship between standards and evaluation processes;
- Applying standards to both clinical and non-clinical staff in the primary health care setting;
- Adopting and adapting existing standards from elsewhere where gaps in Alberta's standards exist, rather than developing new ones from scratch; and
- Striving for efficiency when identifying and selecting standards so that the minimum number of necessary standards are adopted to meet an identified need.

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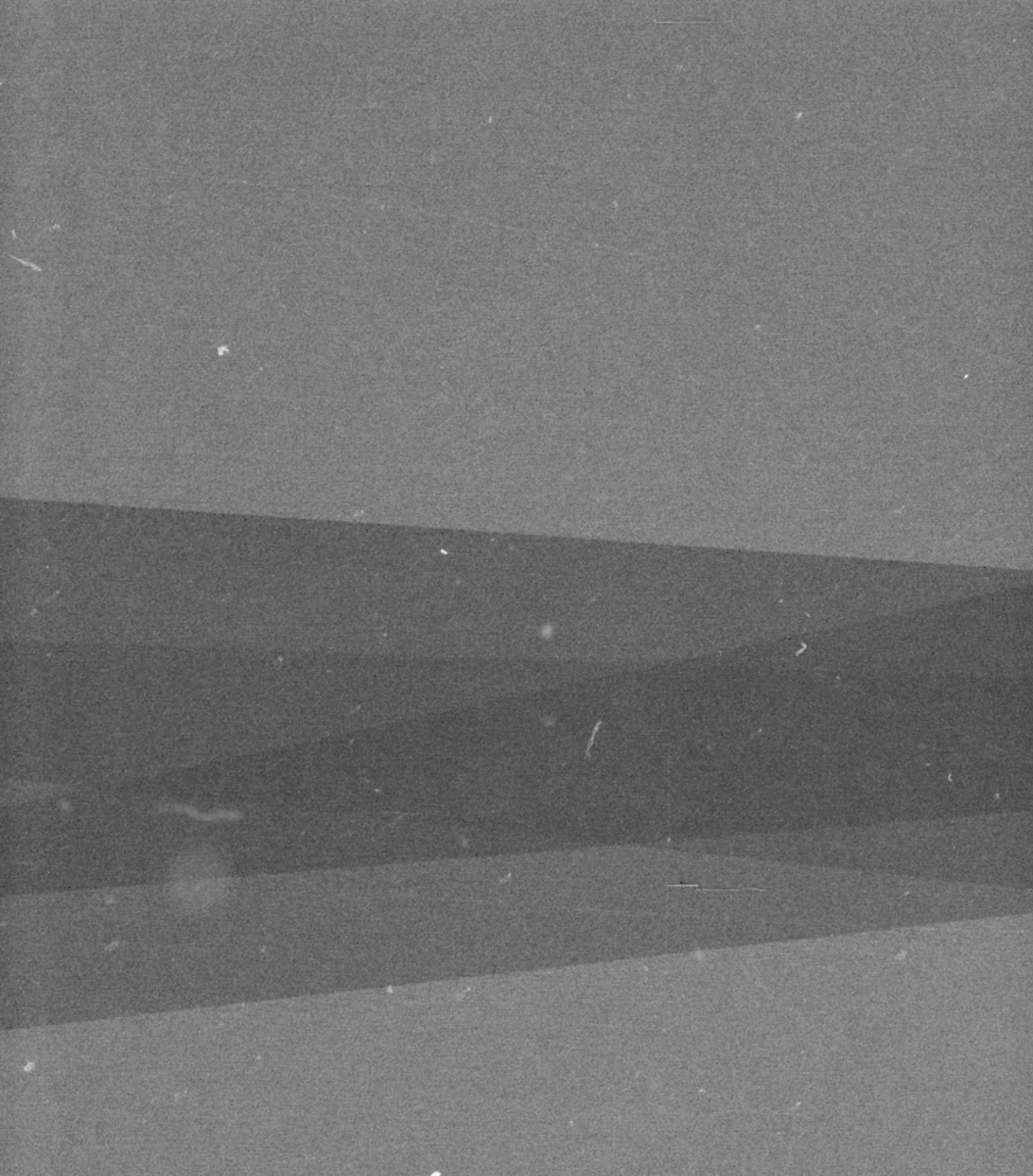

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